

April 29, 2003

Re: MDR #: M2-03-0668-01  
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic Surgery.

Clinical History:

This 55-year-old male claimant injured his right shoulder while at work on \_\_\_\_. The initial MRI on 08/26/02 revealed a partial tear of the undersurface of the distal supraspinatus tendon, tendinosis of the distal infraspinatus tendon, and prominence of the labral sulcus vs. tear of the superior aspect of the glenoid labrum. He underwent a manipulation under anesthesia on 09/23/02 for severe adhesive capsulitis, torn rotator cuff, Type 3 acromion, and torn glenoid labrum, in anticipation of rotator cuff repair, acromioplasty, and correction of the glenohumeral joint problems. According to the noted, subsequent MRI with contrast (report unavailable for review) revealed torn rotator cuff, torn glenoid labrum, effusion and acromioclavicular joint osteoarthritis.

Disputed Services:

Right shoulder arthroscopic Bankhart and arthroscopic acromioplasty.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the procedures named above are medically necessary in this case.

Rationale for Decision:

In view of the patient's history of failed trial of conservative management, the physical findings and imaging studies, right shoulder arthroscopic Bankhart and arthroscopic acromioplasty are indicated and medically necessary.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_ is deemed to be a Commission decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity** (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on April 29, 2003